

**PLEASE READ THIS CAREFULLY BEFORE YOU SIGN –THIS IS A CONTRACT BETWEEN YOU AND OMEA**

If selected, I will participate in **ALL** rehearsals and performances of the Northeast Region Orchestra for the **entirety** of their scheduled times as outlined on this sheet.

Improper behavior (as determined by the OMEA site staff, orchestra conductor, or Cleveland State University), unsportsmanlike conduct, destruction of property, possession or use of any chemically controlled substance (including tobacco and alcohol) by any participant may lead to disqualification from Region Orchestra, and possible from all OMEA functions.

Each member must submit a check for their nonrefundable \$40.00 participation fee by October 23, 2015 to their school Director. Directors should mail in all checks together or have students mail them individually to:

Attn.: Scott Astey  
Wilcox Primary School  
9198 Darrow Rd.  
Twinsburg, OH 44087

All checks are to be made out to **OMEA NORTHEAST REGION TREASURER.**

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STUDENT SIGNATURE

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TEACHER SIGNATURE

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PARENT/GUARDIAN SIGNATURE

*At the request of Cleveland State University, please fill out and return with your application this Emergency Medical Authorization Form*

EMERGENCY MEDICAL TREATMENT FORM

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Student Name: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Persons to contact in the event of an emergency (please list at least two):

Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Relation \_\_\_\_\_

Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Relation \_\_\_\_\_

Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Relation \_\_\_\_\_

Student's Medical History: (feel free to use the back)

\_\_\_\_\_  
\_\_\_\_\_

Student's Allergies \_\_\_\_\_

Doctor to be notified: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Alternate Doctor: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Hospital Preference (Cleveland area) \_\_\_\_\_

I do [\_\_\_]/ do not [\_\_\_] hereby give voluntary consent for the medial treatment of my child as parent or legal guardian to all emergency medical personnel such as EMS, physicians, hospitals and/or emergency rooms as may be deemed necessary by those professionals until the person (s) listed above can be notified.

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_